American Association of Community Psychiatrists

Position Statement on Diversity, May 1, 2008, V 2.0

The latest U.S. Census data illuminates the increasing cultural diversity of the United States, requiring clinicians to understand how cultural differences affect diagnosis and treatment. Between 1980 and 2000, the number of Asian Americans increased by 230%, American Indians by 139%, Hispanic Americans by 142%, and African Americans by 32%. In contrast, the Caucasian population increased by 11% (1).

The Accreditation Council of Graduate Medical Education (ACGME) requirements for psychiatric residents now include a familiarity with cultural assessment (2), as does the *American Psychiatric Association (APA) Practice Guidelines for the Psychiatric Assessment of Adults, Second Edition* (3) and the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (DSM-IV-TR) (4) has added new emphasis to understanding of the influence of culture on diagnosis by including an outline for cultural formulation and a glossary of culture bound syndromes.

Cultural diversity includes issues of race, ethnicity, gender identity, language, age, country of origin, sexual orientation, religious/spiritual beliefs, social class, and physical disability. Cultural diversity also includes knowledge about cultural factors in the diagnosis of mental illness, mental health care and in health related behavior (5). Recent publications, such as the Substance Abuse and Mental Health Services Administration (SAMHSA)'s *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups* (6) provides guidelines for cultural competence planning at both the systems and provider levels, with guidance on system design, including quality control, treatment planning, and provider

competencies, including knowledge, skills, and attitudes. *The Surgeon General's Supplement to the Report on Mental Health: Culture, Race, and Ethnicity* (7) stated that "culture counts," and the Institute of Medicine's *Unequal Treatment* (8) indicated that ethnic minority patients have reduced access to services and receive a lower quality of medical and psychiatric treatment than mainstream patients even when socioeconomic status is matched with mainstream patients. The Culturally and Linguistically Appropriate Services (CLAS) Standards includes fourteen standards about culturally competent care, language access services, and organizational support for cultural competence by which the level of incorporation of cultural competence principles can be measured (9). Additionally, a new interpretation of the Civil Rights Act of 1964 has led to the Limited English Proficiency (LEP) (10) guidance, which requires that federal agencies and agencies receiving federal funds offer services in the appropriate language for those clients who have LEP.

The President's New Freedom Commission on Mental Health's *Final Report on Mental Health* supports the incorporation of cultural competence principles to reduce disparities in mental health based on ethnicity (11). *In the Nation's Compelling Interest* notes that physicians of diverse backgrounds must be recruited into the health professions to reduce health disparities (12). Finally, the recent publication of the *Clinical Manual of Cultural Psychiatry* (13), and other similar books indicate the need for more training in this area. The AACP supports the standards represented in these documents, and recommend that they be used in undergraduate and graduate medical education, as well as continuing medical education, and in the development and administration of community mental health services.

In addition, the AACP supports the development of cultural diversity among its membership and within the field of psychiatry and within all programs that provide behavioral health services (including in undergraduate and graduate medical education, in faculty development, in research, in psychiatric administration, and in clinical practice) in order to prepare community psychiatrists to better serve an increasingly more diverse U.S. population. We support the recruitment of people from under-represented groups to become mental health professionals in the community. Data from the American Association of Medical Colleges indicates that there continues to be marked under-representation of certain groups among U.S. medical students, medical school faculties, and Departments of Psychiatry, and practicing clinicians (14). At the same time, mental health clinicians from underrepresented groups have been found to treat diverse populations at rates that are more appropriately matched to clinical needs than mainstream clinicians.

Therefore, the AACP supports the use of information contained in the Surgeon General's *Supplement to the Report on Mental Health*, and books such as the *Clinical Manual of Cultural Psychiatry* to educate mental health professionals to improve the access to services and the quality mental health treatment of ethnic minorities. In addition, the AACP recommends that the CLAS standards and the SAMHSA's *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups* be used to modify existing services to be culturally appropriate to the populations that they serve, and that the LEP guidance should be followed in community mental health services. Finally, the AACP is committed to recruiting and retaining *ethnic minority* **and** *mainstream* medical students

and residents that are interested in serving their communities by working in community mental health providing culturally competent care, and having representation of under-represented groups in its board and membership as well as in academic psychiatry and supports the recommendations in the IOM report, *In the Nation's Compelling Interest.*

References

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